General Consent

Consent to Treat

I consent to and authorize the physicians, nurses and other healthcare providers at Central + Priority Pediatrics to perform appropriate healthcare examinations, treatment, diagnostic testing or medication administration as deemed medically necessary by their professional judgment. I know that there are some risks with all medical treatments and procedures and I understand that no one can guarantee how well treatments or procedures will work.

Central + Priority Pediatrics is a teaching clinic. In addition to my clinician and other medical support staff, I may receive care from people who are in training. They are supervised by licensed health care providers. I may decline to have these individuals involved in my care and this will not affect my care or treatment.

Assignment of Benefits/Payment for Services

I authorize payment of any and all benefits to Central + Priority Pediatrics. I know that I must pay for any charges for my care that are not covered by my insurance, health plan, or government programs. I realize I must cooperate with Central + Priority Pediatrics to get payment for my care. If I am eligible for payment from more than one type of coverage, Central + Priority Pediatrics will return any extra payments to the payor. If I have an unpaid bill at Central + Priority Pediatrics, any refunds due to me will be put on my unpaid bill. If there is money left over after my bill is paid, I will get a refund from Central + Priority Pediatrics.

Release of Information

I consent to and authorize Central + Priority Pediatrics to use and disclose my protected health information for:

- Treatment
- Payment
- Healthcare Operation Purposes, including care coordination and quality assessment and improvement activities.

Releases for these purposes may be made to insurance companies, health plans, government programs, e-prescriber databases, payer network organizations, including clinically integrated networks and/or accountable care organizations in which my provider participates, and other healthcare providers involved in my care and treatment. Additionally, I consent to and authorize my insurance company to share any of my protected health information for the purposes stated above to Central + Priority Pediatrics and/or a clinically integrated network or accountable care organization in which Central + Priority Pediatrics participates.

Patient Rights and Privacy Practices

You and your family's rights and our privacy practices are posted in main areas within Central + Priority Pediatrics. Your signature acknowledges receipt of our Notice of Privacy Practices. If you have any questions concerning your rights and/or our privacy practices, please contact your care provider or Central + Priority Pediatrics' Privacy Officer.

Other Individuals Authorized to Consent to Treatment

In addition to the legal guardians of the patient, the following persons are authorized to consent to recommended medical care for my child: name and relationship to patient (e.g., grandma, grandpa, daycare provider, etc.):

Name:	**Relationship to child:**
1._____	_____
2._____	_____
3._____	_____

My signature here means I have read this information and understand it. This consent is valid until revoked in writing.

Patient Name: _____ **Date of Birth:** _____ **Date:** _____

Signature: _____ **Print Name:** _____ **Relationship to Patient:** _____

Parent Email Address: _____ **Name of Interpreter (if used):** _____

Telephone consent obtained by (Name/Date/Title): _____

central+ priority PEDIATRICS